

SERVICES, SUPPORT AND SYSTEMS > CHILD ADOLESCENT & FAMILY SERVICES (CAF) > RESPONDING TO REFERRALS

Responding to Referrals

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1. Responding to Referrals - What is CAF and what are routine referrals_

My name is Shelly and I'm a parent who has accessed CAF for one of two of my three children. Kia ora, I'm Laura Hay and I'm a registered nurse within the CAF Access team. Hello, I'm Tisha Bradley, I'm the clinical manager of the CAF Access team and a registered nurse. Kia ora tatou, my name is Mireia Rusbridge and I am a Pekinga Atawhai, so I'm the cultural umbrella within our kāna kō whānau. Ngā mihi. I'm so delighted to be here with you today ladies and I understand we're going to talk about routine referrals to CAF. Can we just set the scene by talking about what CAF is and what a routine referral looks like please?

So CAF stands for Child, Adolescent and Family Mental Health Services and we are a tertiary organisation, so we don't mean that it's that people have gone through other areas before they get to us and we look at young people from the perspective of our criteria. Which meet the criteria for high, moderate to severe mental health issues and we're hoping that when a GP makes the referral that the young person and their whānau have actually had some input from some community organisations and those community organisations that we often refer to will be things, places like Mana Kuriri who look at the young people that, from the age of 30, 13 to 25, or mana ake in primary schools, which is in intermediate schools, and also Methodist Mission, Presbyterian Support, Catholic Social Services.

There's a huge amount of resources out there for young people and their whānau to have tried beforehand. Parenting programs are available. When we say routine, our team is made up of, we have routine referrals, which is called CAF Link, and then we have an emergency side, which is CAF Emergency, and all emergency phone calls and assessments come into that space. So today we're just talking about the routine. Okay, so your referrals are coming from GPs? Yep, GPs. GPs only, for the routine referrals. And GPs can access community health pathways to guide them in relation to what the referral may be about.

So it may be for ADHD, it may be for a mood disorder, anxiety. And there's processes within there, when the family whānau and the young person go to the GP, that the GP can look to see, oh, how do I make this referral? And also within that space, there's a lot of work that needs to be done, and there's a lot of work that needs to be done, and there's a lot of work that needs to be done. So it's in that space that they look at in the pathway. There are NGO, non-government organisations that are available there that they could redirect the family to. We're getting more referrals coming through from nurse practitioners as well.

They're setting up more within GP practices, so we are actually able to accept referrals from nurse practitioners as well. So it has to be a GP surgery that are making that referral? Mm hm. So the GP or the family? Yes. like Laura was saying, the nurse practitioner. So it would be quite reasonable that if I was going to my GP to arrange a referral for my child, that the GP might ask questions about what are the pathways I've already accessed before they would want to support my referral to the practice. And we would love that to be within that information and for the family to go along armed with a whole lot of stuff.

If they've got that, you know, forms and reports, if they've got any things like that, it's always really handy to have.

2. Responding to Referrals - Information to support a CAF referral

As a parent and I don't know what I'm going to the GP with, what are the steps that I can take in advance of going to the GP that might be useful for me to know if it's even worth my time? You know it's a big effort even to get into a GP these days or a nurse practitioner. There's lots of things that can be done in advance because for example if we get a referral through for a young person who has had no community-based intervention whatsoever chances are that's what's good that's what our recommendation is going to be is try these things first and then come back to us. So Tisha mentioned before community health pathways so all GPs all nurse practitioners have access to community health pathways and there is there are pathways for literally everything so that includes all the mental health kind of stuff as well.

It's got copy copies of things like like so for example if you come wondering about ADHD for your child we've got specific forms here's one I prepared earlier so just using ADHD as an example we need these snap forms CADRA forms which are tick box forms we need one from a teacher we need one from a parent and then we get magically the school support form as well so it's all this is all necessary information for us to have and if we don't have this if a referral comes through asking about ADHD and we don't have all of that information we have to decline it because we don't have enough information to do the proper triage process that we need to do and we can't go any further without it.

But you would email them back at that point saying get this information prepared and contact these NGOs and access these services. Absolutely. And then you can refer them. Yes absolutely. And then just making sure that you've kind of got all your I's dotted and T's crossed and those kind of things but this stuff can the GPs can access all of these forms the school support forms can be accessed by the classroom teachers and they're available to them they would be supportive for any referral that we get through really the more information we get the better. And there are other types of forms for other pathways or other evidence that could be gathered by family?

Yes like if they had been through other community-based organisations something in writing to say this is what happened this is how many sessions we had these are the struggles that this young person is still having despite input from our service all of that stuff is really helpful stuff. And that's including sometimes the young person will go to a private psychologist for instance and that psychologist may do a report and if there is a report available and then the GP's making that referral to us for us to have that additional information is really fantastic to actually help us make a really good informed decision for what should happen to the young person.

The more kōrero the better. Yeah. So I think my lived experience is that it's useful to get notes attached to a child's GP records at the medical practice as things occur. If you have an email from a teacher that describes the situation at campus. If you have an email from a teacher that describes a situation it can be useful to forward it to your GP practice say please attach this note to my child's record that's that's the sort of stuff that we're talking about that you know if because you're then the GP can then share that with us you know rather than us then trying to chase the family who are really busy and if you've already provided that information before and then we may not have consent to be contacting the school to get that information directly it just makes our process so much more easy to have as much stuff as possible to make a really good decision

3. Responding to Referrals – Pressure on the service – triaging each referral

So I understand that the service is actually quite slammed and I'm kind of worried about you guys. How are you doing? We are really under pressure and the mahi just keeps coming in and we have an amazing team within the access team who really, every person that's referred in is looked at as an individual. You know we are human, most of us have got our own kids and we appreciate that this is about this person's child. We may have the huge volume of referrals per year but that's insignificant to that family whānau. This is about their child and we understand that. We understand that this is so important to them, that we take a lot of time to actually really look at that referral and really work it up as much as we can.

possible from the perspective of what's going on for that young person and the family whānau. So we know from research from in December in 2023 there was the Royal Australian New Zealand College of Psychiatry quoted that in the last four or five years there's been a 50% increase within specialist mental health services referral rate and that is definitely the case within our service, the Waitaha Canterbury specialist mental health service, CAF, situation. We're really under pressure and due to that we have, you know, it takes a long time for us to see people which is really stressful for families and that young person and again we know that, you know, it would be fabulous if we could get the person in really quickly and see them but we just can't do it because things get worse.

But we're, like we said earlier on, you know, if things do get worse and parents have a question, if the person's been referred in, there is a whole process that goes on once we, if we accept that referral and the person goes to an outpatient team. There's contact from that outpatient team every three months. If anything gets really stressful in that time they can contact that team or contact us, crisis, the emergency function of our team, or the crisis resolution team after ours. So we're really, really aware that there's just this huge explosion and we have no idea why that is. And it's really hard for young kids and their family to be going through this stuff.

And for you trying to staff at an adequate level. Yeah, yep. With so many more numbers coming in. It's great when you've got a really fantastic bunch of people that really care about what they're doing and have really got that, we're really patient, you know, we call them patients. Yeah. they're not we've really got that young person at the heart of what we're doing because it's about their future yeah yeah if we don't feed them now then they're just going to become another statistic we don't want that and the detrimental effect that not having the right treatment or the right care or us directing that person to go to an ngo that we know will hopefully support that uh what's going on for them you know the the sooner you get on to that and the sooner that starts happening that the better outcome for that young person

4. Responding to Referrals – CAF or Child Development service

So the Child Development Service, what is it and how would you, why would you refer to it rather than CAF or Vickie Berker? The Paediatric Development Service is quite different from CAF. So they're based at Christchurch Hospital and they work mostly with developmental concerns. So like global developmental delay and things like autism, things like that up to the age of 15. So if you're a young person, you've got questions about potential autism, then the referral would be directed to paediatrics for a review of that. But for anything else, mental health concerns, ADHD, anxiety, low mood, all of that stuff comes to us.

It's quite different across the country. There's lots of different areas of Te Whata Ora work things quite differently. But for us here, in Christchurch, yeah, the paediatric team do the autism assessments in those under the age of 15. And any other mental health concerns tend to come to us. So the GPs suss out kind of which pathway they should go on, gather the appropriate information. Spoiler alert, we need the school support form for both services. We both use the same paperwork and that school support for health and wellbeing form. That was developed by paed, us and schools so that they would get a really broad overview of what is going on for that young person.

So it looks at a wide range of things like how the young person learns. How do they interact with their peers? What are the concerns that school has? The parent has the opportunity to kind of give us that information within the referral from the GP. So it's gold. Having that information come from the school as well. And like I say, paediatrics need that supporting information for their triage process as well. And the GP, sometimes it gets a bit confusing for GPs. So they may inadvertently refer to the CAF services when they should have actually referred to the paed developmental team. And we will redirect that back and say this to the GP.

This should have got in the family. We always get a copy of all our letters that we send to the GP. That this should have gone to the paediatric developmental team because you're querying, so for instance, autism. And there's information I understand within the listening to families videos about ASD, about ADHD, about lots of anxiety. Lots of different reasons why the GP may be referring to us. So it's a really good place for the family to find out. Even the young person to go and have a look and suss it out a little bit more. So that would be a good way maybe before they go to the GP to have a look there.

To think, oh is that something that I'm going for? What do we actually think it may be? Teachers, anybody can have a look at it. It's a great resource. With all our information that we send back to Family Whānau, we put one of the listening to families cards in with all our letters. So that they get that information about how to access that. How to access the resource. We also do work really closely with paediatrics. I'm the liaison clinician who kind of works between both. So it works really well if we have a case that we think, should we maybe be sending this over to paediatrics? I can triage it with them and vice versa.

If they have cases that they think we might need some calf support with this one. They'll give me a call and have a chat through. That as well. So yeah, we've actually got quite a solid relationship with them now, which is great. But not all referrals that, the non-urgent, the routine referrals that come in. We won't do that with every single one. If it's very clear that the person's under 15 and from the information that we've got that it's ASD, autism. We will just send that back to the GP. For the GP to do that. Because the GP is the primary carer for that family from a medical and mental health perspective.

And for them to be understanding what's going on for that young person and the family whānau. And to support them is a really good place for your body to have that information. That one central place. I feel like you're saying, so you wouldn't just forward the referral on to child development services? Like as a parent, I want you just to make it happen. Yeah, that's fair. Yeah, not always. As clinicians, we would like the GP to make that happen. So it doesn't necessarily fall back on the family to make another appointment and go back to the GP and say, can you do this referral? In an ideal world, what would happen is we would respond to that referral and say, we think you're asking about autism and someone who's under 15.

Here's the correct pathway where it should go. And while the family would get a copy of that communication. I guess we would hope that the GP would respond. Yeah. And the GP would just follow that through and make that referral through to paediatrics without having to get the family back in. Because hopefully they would have all of the required information before it was sent through to us anyway. And also the family whānau can ring the GP and say, look, I've just got this letter. Can you advise me rather than making an appointment? The reception team may be able to actually speak to the doctor or send it through to the practice nurses.

Yeah. Or the nurse practitioner there. And they may be able to say, yep, we're on to it. Or they may want them to come back to tease that out a little bit more. But that, again, sits with the GP to do that. And like Laura said, we're hoping that the GP will go, I can do that, and sends it off and lets the family know. From our point of view, your general practitioner and nurse practitioner, they're your primary caregiver, really. So they need to be that central hub that has all the information. And they need to be the ones that makes those referrals. Because then if you as a family go back to the GP in three months' time and say, I haven't heard anything, they're the ones who are going to follow that up on your behalf.

So, yeah, they need to be the ones who kind of know the pathways the best. And we understand that primary care GPs, nurse practitioners, they are just so slammed in that space as well. And so making a phone call, you know, may be beneficial. Because they may be able to say, yeah, I've got this. They may be able to sort that in amongst other, you know, when they may have a time slot that they can actually think about, oh, how do we do this? Can we do this? And then follow up rather than having to, the cost of going to the GP and things like that, you know. So there's pressure everywhere in the system.

And we acknowledge that GPs are really stretched. And we are aware, just as we are stretched, that the GP needs to know that stuff. They're going to look after that family long term and the young person. We try to be supportive and give the correct information.

5. Responding to Referrals - Processing referrals – accept

Oh, now we're going to get on to the gold of what happens when you get referrals. So you've got a referral, what is the pathways that you guys follow in your team? So the family whānau will go to the GP, a referral will come through to us, and then the triage process happens. So every referral that comes through has what we call a risk screen. So we screen the referral information that's in the information that's come from the GP to make sure that there's no kind of imminent risk stuff that we need to be acting on straight away. And if it is in fact a routine referral, those referrals are then distributed among the team to work up.

So there's lots of different things that we look at. We look at what is their medical history? Have they had any referrals through to us before? What else do we look at? Have we given recommendations previously? How many times they've been referred in in the last wee while, or was it a long time ago? We can see if they've had any interactions with paediatrics or other kind of services within the South Island to Whātūora as well. What medications they're on. We look at a whole lot. We look at a lot of background information before we even start looking at what's happening right now. And then it's a case of looking through what is happening right now.

Have we got the right information? Do we need to call the family and get a bit more information on what does that kind of look like? And that's even before we make the decision whether they are accepted into the service or not, or what's actually going to happen with them. And once we've done that, within three days we are taking, or even immediately, four days of information. If we've got the ability,

three working days, we take that information about that young person that we've got and hopefully we've got everything that we need. And it's discussed at our multi-discipline team meeting where again, Maria is sitting.

We have a consultant psychiatrist that sits in that space. We have at times a clinical psychologist. We have registered nurses, social workers, clinical nurses. We have nurse specialists. Sometimes I was in that space as well. So there's quite, it's not just one or two people. We, there's a whole team, but initially the one clinician will work it all up. And we're really mindful that this is that family member is really invested in this referral coming to the CAF services. And we are all parents. A lot of us are parents. And we are all parents. And we are all parents. And we are all parents. And we are all parents.

And we are all parents. And a lot of us in the team are parents. And we work up each case as that individual person. We actually, we really think about what's going on for that family whānau, what's going on for that young person. And we feel for them. We feel for them. So we're not robots. We're human. And we, each one we look at is just about that one person. But the great thing about having all those people is that we're not robots. Those are just, you know, robots. We have the flexibility. We have the flexibility. But the fun part about having all those individuals is that we're able to put in what we're seeing and what we're hearing.

We have some robust conversations here. We do. At MDT. And a lot of the whānau that I work for, we're passionate. And there are some that go, oh, no. And then there's some of us, no, it's happening because of da, da, da, da, da. And they will bring out their points. So, it just doesn't happen like, oh, five seconds, it's over. We actually can sit in MDT in one case for a good five, 10, 20 minutes of no, no, no, no, no. depending on what's being presented so we don't take any person, whether they're Maori, non-Maori whatever, ethnically we really think about what is the best option, how do we give the best to these rangatahi and whānau that come through our doors you know, so it's never done ever lightly, ever at all so that's what I like about our team.

Yeah, one of the great parts about it is it's never just on one person, so like we say there's that one clinician who gathers all of that information together but actually the final decision that is made for what's the best way forward for this whānau is a whole team decision, so it's like eight people deciding rather than just one. So what are the possible decisions that you could make?

Okay, there's a few different things so if the young person meets criteria for service that would be accepting onto our pathways, that would indicate that there has been a trial of a community based service and there's evidence that a high, moderate to severe psychiatric illness may be present and that needs specialist mental health input We look at things like functional decline as well for that person and when we talk about that it's like how are they sleeping, how are they eating what's their mood like, what's their concentration are they enjoying things?

So that's when we're hoping that that information is within the GP referral and we call it an ERMS which is an electronic referral method and that's how we get that information from the GP and if it's really clear that that is the case like we were saying we will accept them onto the waitlist Another big part of that functional decline stuff is are they going to school?

In the adult sector they look at is this person going to work, are they kind of living day to day life as they should for children they don't go to work but they do go to school and they might be engaging in extracurricular activities sports, things like that so has there been a change in that side of things as well so it kind of is a whole picture of actually everything is quite severe And we talked a little bit before about sort of information that we received and I just thought about that when Laura was saying that sometimes we have young people referred in and that young person because you were talking about education is having their education by home learning that they're having their learning at home so we talked about the forms before that we wanted them from a parent a teacher in the school supporting information so we would we think outside the box and and we if the person does go to extracurricular activities we'd be saying well take that SNAPS form to the karate coach and tutor and get them to fill it out what they are seeing so to accept someone we need all that information like we talked about and they need to have that moderate high moderate to severe mental health and that functional decline and we're aware of every patient being a member and being a part of an organisation parent feels that their child that's being referred in at that particular time meets that criteria.

But we have that, we are a tertiary service and we have that ability to actually really tease that information out to actually, do they meet criteria? So the first thing that you ask before is like, what are the options? And that's, that we would accept that person if they do meet that criteria. And you mentioned that if they did meet the criteria at this stage for routine presentations, which is still high moderate, they're going to go on a waitlist. They are going to be on a waitlist. And we are often now within our team sending a letter to the family whānau and the GP acknowledging that we're going to put this person through, they meet criteria, and we're giving them some of those NGO options that we talked about before to go to.

So we can try those in the community whilst they're waiting. Unfortunately, some of those, if you're on a waitlist, you can't actually access them, but we are aware of that, and we will just give the recommendations of one that they can access.

6. Responding to Referrals - Processing referrals - seeking further information

And then the other options. More options. So if the referral information comes through and we've managed to work it up and we're still a little bit unsure as to whether the young person and their family meet criteria or not, we might offer what we call a non-acute triage assessment, which is basically a one-hour screening appointment. So a clinician will meet with that young person and their family on a face-to-face basis and just tease things out even more. Because sometimes we understand that families are actually quite complex, so there's often a lot of stuff going on. It's rarely it's just this one issue and that's it.

So sometimes it just does need that little bit more in a face-to-face way, just teasing things out to see do they meet criteria for service or is it that there's a more appropriate community-based service that might work for them? It might help because we can't get all the information sometimes that we need on the telephone when we're doing our information gathering to find out what's going on. And we can't always get it right, so that is an option that we use. But within our space we do a lot of work over the telephone and we will always say to the family, look, we're ringing up to talk to you more about your child.

Is this a good opportunity or when's a good time? Is this a good time for us to actually call you back? The appointments that Laura was talking about, what we call a nata, maria, if the person identifies as being Maori, then there is always a pūkenga atifi, a cultural lens within that space that will be there to support that whānau and that rangatahi during that time.

7. Responding to Referrals - Processing referrals - redirect

Then we do what we call redirect. So we're redirecting a person to the right pathway, basically. So they've come to us, but actually we're not the right pathway for that person to be going on. And that's after, again, the same process where we've done a whole lot of mahi to try and find out what's going on for them. Often the GP referral is absolutely fantastic, and we can get what we need from there and all the other information that's been to make a really clear decision. No, they don't meet our criteria, and we give them a whole lot of options in the community that we talked about earlier on.

So, yeah, and we look at, like Laura said, all that previous history, their medical history, do we know them, what have they tried, you know, and if they haven't, often we'll get a referral back in quite quickly. And so we'll look and think, have they actually done those recommendations that we actually sent out previously, you know, whether that's mana kōrero or mana aki, and if not, why not, and do we need to support whānau to do that, to access that, and is that something that we can help, or do we need to give clearer instructions, what have we done? We don't just, again, go, you're going to go back, but to that.

But we want you to have actually done that, and we want you to have done a really good trial in that space before, not just one or two sessions, because you actually, those one or two sessions is actually getting to know that person more so than actually doing the work that you're going along for. You might be going along to do, look at some anxiety work, exposure type work within that space. As another part of that redirect process, sometimes we'll get things through for, say, ADHD, for example, where we've got all of the information that we need, it's all really well filled in, but things like the SNAP forms, we have to have threshold levels that they need to reach, and if they don't meet those levels, then we just can't accept them onto the pathway.

We've kind of already talked about the pressures on the system and things like that, so we have to really just look at that moderate, severe type presentation. So in that case, we would look at what is the information that's been provided, is there something else going on that might not necessarily be ADHD but might look a little bit like ADHD, and try and work things up through that lens as well, and then try and redirect to an appropriate service for what we think might be going on there. And when we do all that gathering of information, if we need to ring a school or another, or another organisation that's been involved with this person, we always get permission.

So we need consent from whānau to actually be ringing those people. So we don't just randomly ring up the school and go, oh, we've had a referral for you, such and such, because the family might not want that to happen. They may say, no, we don't want you to contact the school. Or the family may have asked the GP to include that information that I give consent, the family gives consent to contact the school, this is the person. Or it may be in that school health and wellbeing information. So we've actually got a link to the person that we need to. But we would never just go in and ring people that we haven't actually spoken to whānau about or have permission to do that.

Yeah, we don't do cold calls. No, directly. No, not in the community. No, we're not looking for business. No, and I suppose when we're part of the redirectors, part of the MDT is, you know, from a cultural, I'm there to do a cultural assessment, which is a te aro tākenga. Are they connected to their iwis? Is there funding there for them to get, to go to Seabrook McKenzie and some services that are out there? So that's really important. Are you connected? If you're not, then you need to, would you like to be reconnected? And so part of the redirect is to, are you connected? Are you registered? Does your iwi have funding?

Because that stops a lot of our whānau from actually engaging because it's about the pūtea. Because \$300 for an assessment is a lot of money for many families. It might be even more than that. I think it's a bit more than that, but I think it is. And also Maria will be not necessarily, we won't be writing that in the letter, Maria will be ringing the family whānau and actually speaking to them directly about that and then including that information within that letter. Because. Just getting a letter is pretty impersonal, but because we are so under pressure, often that's what we end up doing. And a lot of work goes into that letter that ends up going back to the family whānau, the young person and the GP.

And often all you're going to read is that first part that your child's not been accepted. And then that would be heartbreaking. And you're like, oh, these bloomin' people, so-and-so's, and you screw it up and chuck it in the bin. And we totally get that. Again, we're family members. We're parts of families. We wouldn't like to get that as well. But that's why I said before, a whole lot of work goes into actually writing that letter. It's not just a robotic letter that's just generated. Yes, we've got a standard template, but we then put within that stuff, according to that family, in any of those letters that we're sending out.

8. Responding to Referrals - Processing referrals – decline

Yeah, I guess the other option that we have when we get referrals through is decline. I mean, we very rarely will actually just outright decline a referral that comes through and 99.9% of the time the declines happen because we don't have enough information. So, that might be, the ADHD ones often will come through without the right information, so without those SNAP forms, without the supporting school information, so those would just be outright declined because we can't do anything with it if we don't have all of the information. And we used to chase that information, but we have so many referrals coming in, we just don't have the time to do that chasing and following up, and it is really clear in that community health pathway.

So, we don't have the time. And the GP is making that referral of what we would require, so that's why we would decline it. And we don't have the physical space. Whenever a referral comes in, it's made up into a physical folder with information, all the gathered information in it. And if we were to hold open all the incomplete referrals, we would just run out of room. So it's a physical space thing and it's a capacity thing. So if we don't have all of that. If we don't have all of the information that is necessary, then we will decline. And the other times, it's not just ADHD ones, the majority that we decline probably are that we don't have that paperwork.

That would be it. Yeah. Or if there are a couple that we will get referrals from a GP or a nurse practitioner and there will be maybe two sentences of information, we can't go off that. There's just not enough. And to just say things like, behaviour concerns, please see. Sorry, no. Because what we want to know, what are the concerns? What's going on? What's happening? Why? When does this happen? Yeah. So yeah, for the most part, the things that we will do is redirect, and then probably next on the list would be our triaging, the face-to-face triaging. And accepting into service, and then the declines only happen when we don't have the required information.

And does the decline include the instruction for the GP to go back to the health? Yes. Always. Yes. We love community health pathways. Yes. Yeah. And we have specific things that we will send out and often are copied and pasted from community health pathways that say, here are the things that as per community health pathways, here are the things that we need in a referral from you. And we'll say, please refer back once you have all these things. Yeah. Yeah. So it's not like you go away and never come back. It's like, go away and get these, and then send us that information. And if it's like the ADHD ones, we will be crystal clear as to, we need this, this, and this.

You have provided this and this, but not this. Please get this, and then come back to us there. Or if it's clear from that incomplete referral. But actually the SNAP scores are really low, and we're probably not going to go any further with it. We would probably include something to that effect in that decline letter as well, and say, you may wish to re-refer, however, just be aware that based on what we've got, it's unlikely that they would meet our threshold for further investigation. And that decline letter also goes to family whānau so they know. Yeah. And that, when we do have family whānau that ring up and say, we need this.

We need this. We need this. We need this. We need that. We need that. We need that. So, we gave that to the GP. And it's just been lost in the system, and we say, look, we haven't got it. What we'll do is please get that and then we will reopen that file from when we get that information. So we're not really cold-hearted people that go away and never come back. We actually, we hear that. You know, people are busy. GPs are busy and things get lost. Because things happen. Yeah. Life happens. Yeah. So we will sort it out. Yeah. We're pretty flexible.

9. Responding to Referrals - My other children were seen by CAF why has my youngest been d

So I have a friend who's got three kids and the first two went through the CAF service and the third one, who seems more extreme to me, has been declined. How can it be when you've got two that get through, the third might get declined? So, as we kind of mentioned before, we have huge pressures on our system and it might be that things have changed from when the first two young people went

through and, you know, are kind of... Like the threshold for acceptance into the service. Unfortunately, yeah. Unfortunately, yeah. So we have to be really clear that for referrals to be accepted through, we're looking at the high, moderate to severe end of a mental health presentation.

Previously, the demand wasn't as high and the pressure wasn't as bad as it kind of is now. So it was more of that whole moderate to severe. But the goalposts have had to move just based on if we accepted everyone in that moderate to severe, we would end up with waitlists spanning two to three years. And we absolutely don't want that. And so it may be that in the time that between your children being referred maybe the goalposts have moved a little bit, but we would still treat and triage every referral that comes through as that individual and look at all of that past history and information and things like that before we make a decision going forward.

So, for example, if two of her three kids are ADHD and she's really just looking for an ADHD referral for number three, what are the community pathways for her if it's not through... child and adolescent family mental health service? So if the GP has sent all the relevant information to us and it does meet criteria, of course, we're going to see that young person because it's clear from the information that we've got that it's ADHD. There are other options out there if family whānau can afford that or if they can access funding that they may want to go private. We can actually have a look at some of those options in the private space.

There's psychologists, occupational therapists. There's a whole range of people out there that can actually offer those supports as well. But in relation to ADHD, that's probably an easy one for us to say yes or no to, like we talked about a little bit before. But often if a person has ADHD, and there's a sibling coming through, yes, that sibling potentially could have ADHD, but not necessarily. It may be ASD, and that may be something that needs to be looked at. So, yeah.

10. Responding to Referrals - Cultural support

It's wonderful that we can support the cultural needs of families. Can you speak more about what cultural needs are met or how they might be met? For Māori whānau and for my own whānau myself, it's meeting people kanohi ki te kanohi. Often when you get a phone call, it's quite impersonal. You can't actually read the ahoa of that person you're talking to. So for me, from a cultural perspective, seeing the whānau, getting an awareness of them, and you actually have better interactions. But the clinical whānau that I work with, they're brilliant in the way that they kōrero. And they offer me, often I say, would I offer a clinician to an assessment?

No, because it's part of our mahi. That culture will be there as well as our case managers. So when they do come, my mahi is to make our whānau feel at ease. Because not just for Māori, but all ethnicities coming into a cold, sterile environment is very important. Wewi Wawa is very anxiety-driven and anxious. So my mahi is to, first of all, just to calm them and say, hey, we're here to listen. Because that's our mahi, is to listen. It's not about what we want. How can we support you and your rangatahi, your babies and your whānau in this environment? Because it is a scary, sterile institution.

So let's change it. And more Māori are starting to come back into our service. And whether we like it or not, it's a fact. You see a brown face. It's kia ora. And then you meet our clinicians and then they get it. Actually, we work in harmony. It's what we're meant to be working together as one. So I like that concept. And our whānau are at ease. People say that when you start with a karaki, it's a prayer. Well, actually, it's not. It's taken away that wewi, that the unknown, the uncertainty, are coming into an area or an assessment of feeling OK. And it's about reminding them it's about whānau, and it's about listening, and it's how we can support you.

We're not going to get it right all the time, but we do our damndest to do it and to wrap around the Māori NGO services or non-Māori NGO services, because a lot of the hara and the pain come from our whānau. So we try and use as many services as we can for our babies. It works out really well. Maria is always part of our MDT. team discussions, so even if she doesn't get a chance to interact with that whānau one-on-one, there's that background kind of input from her perspective as well. So that's across both the emergency and the non-emergency teams. And that's the multidisciplinary team? Yes.

Yes. Yeah. And what I also like to tell is sometimes we can actually go into the community with the case manager, with one of my colleagues, and actually take the whānau to the community. And I think that's one of the things that I like about our services, is that we can get the services to meet them, because that's another stigma, is getting them there. And the one thing I like about our services, how can we think about petrol, where do they live? Because a lot of services, they just do referrals, referrals, but it's about the cost. How many other people in that whānau? So if we can get them there across, that's the first step, to meet that service, to find that trust and that faith, then I've done my job.

And then we try and follow up and make sure they engage before we think about discharging. And my team are pretty good. Please, please hold on to them for another couple of weeks until I know they're engaging or being part of that service. And Maria is talking more so about when we're actually a person's brought into more so the CAF emergency space. And also we have, like Laura said, Maria sits within our... We have a multi-discipline team meeting, and for all the non-urgent people that are referred in, all non-urgent referrals,

sometimes those referrals are actually, we screen them and they actually are more urgent than what the GP's actually said, and then we will sort that young person out to be actually followed up by CAF emergency and do some work.

And Maria sits within that MDT space for all non-urgent referrals. So those are the people that often we don't see those people. And we're giving recommendations, like I talked about before, and Maria's input from a cultural point of view of where that whānau can access supports in relation to their culture, whether that's sometimes it's not necessarily just because that person's Māori, it may also be because Maria's got some thoughts about that young person that may be Pākehā, that may be Samoan, Pasifika. So there's an oversight. There's an oversight from a cultural perspective all the time in all our settings.

And do we know it's making a difference? I think for some of the, because I still get emails from those that have been redirected back into NGOs, I've got emails from Te Pūna Oranga to say that we're still working with this young kotero or ngā mātua ka Maria, I've still got daratara and they're doing really well. So for me, we're not going to get it right. We're going to get it right all the time for some of our rangatahi because they just don't want to engage. But when you get feedback like that, I always let the team know or the case manager that I've been working with to say, hey, look, this has happened, or if they've been picked up or they haven't been picked up, because that's important for us, because I know that they're going to come back.

And that's the sad thing. I don't want them to come back. My job is to keep them out of our system as much as we can from a cultural perspective.

11. Responding to Referrals - Involving a support person – phone call or appointment

If I needed to take a support person with me to my face-to-face or my phone appointment because it might be that, you know, how do I arrange for that if I need support? You absolutely are more than welcome to bring support people, we would actively encourage you to do that. When you come to these appointments you can be overwhelmed with the amount of information that is kind of given or asked of you, so if you are coming to a face-to-face assessment you're absolutely able to bring a support person. Maybe just let us know in advance so that we can book a room big enough. In terms of phone triage, when we call to kind of ask questions, further questions about the referral that we've received, we will always say, is now a convenient time to have a chat about this?

You are absolutely welcome to be like, no, at this point in time I would rather have a support person here with me, can you call me back? Or I can call you, back when I'm more available or I have that support person, or you can give us a day and time and we'll try and make that work as well. Keeping in mind that we only work business hours. Yeah, we're not going to call you eight o'clock at night, sorry, but we will try our best to be flexible for you guys. And when we said in kanohe ki te kanohe face-to-face we say, bring your whānau, but it's like Laura said, tell us how many so we've got enough space, you know, because it's about the journey.

And what's been happening within the whole whānau, not just our rangatahi when we see them. And you actually get really good visuals and ahoā of what's really going on for the rangatahi and the way they interact with the whānau, which is good for us because then we go, oh, oh. Yeah. And then that's when we say, OK, whānau, out, because we need to have a korero with our rangatahi and, whoa, the world opens and they talk to us in a really honest and open way. And that's why it is important. It's important to bring whānau, friends, and it doesn't have to be blood tūtū. It can be youth group whānau.

It can be anyone that you feel connected to. That's the great thing about a support person. Great.

12. Responding to Referrals - Re-referral after the referral has been redirected or decline

So I've had the decline from a letter that's come through from CAF for my referral and I just want the GP to reapply again. So we talked a little bit before about our processes of how we look at all the information that we've got and if we have given recommendations that have not been followed up, we are going to say, well, no, please go away and do these in the first instance before we actually will look at whether they meet criteria, unless there's significant additional information that we get. But we're always happy for anybody to resubmit a referral, but take the time to read what we've actually recommended and go and do those things in the first instance. Yeah, and I think for our processes, there's a difference between that redirecting, where we've made those suggestions, so we would strongly hope that the whānau had gone and done those things, versus a decline where it's been not enough information. So if the GP has referred one day, we've declined it because the forms are not there, the GP could refer again the next day if all of that information is available. So if it's a decline for not enough information, then you can re-refer as soon as you like. If it's that redirect where we've said, actually, this communication, really based support seems more appropriate at this time, we would hope that the whānau would have gone and done that first before they come back to try us again.

13. Responding to Referrals - Making a complaint – advocacy services

And we talked about before levels that need to be met to access the service. If I am genuinely unhappy that I've been declined and I want to lay a complaint because I'm not happy that the level's shifted, what are my options? Well, there's a nationwide health and disability advocacy service, and you can access that to give you support of how to navigate that process if you want to make a complaint. So that's available. Again, if people want more clarity because they've just received a letter, give us a phone call and actually speak to one of the clinicians who can talk you through that stuff. And that may alleviate you wanting to make a complaint because it's clearer than just receiving that information in written form.